Federal Update
for
May 19 - 23, 2014

Statement from Secretary of Veterans Affairs Eric K. Shinseki

May 16, 2014

WASHINGTON – Secretary of Veterans Affairs Eric K. Shinseki made the following statement:

“Today, I accepted the resignation of Dr. Robert Petzel, Under Secretary for Health in the Department of Veterans Affairs.

"As we know from the Veteran community, most Veterans are satisfied with the quality of their VA health care, but we must do more to improve timely access to that care.

"I am committed to strengthening Veterans’ trust and confidence in their VA healthcare system.

"I thank Dr. Petzel for his four decades of service to Veterans.”

Message to Veterans from the Secretary of Veterans Affairs

Fellow Veterans and Family Members,

After 38 years in The Army, I am now honored and privileged to serve as your Secretary of Veterans Affairs (VA). VA remains committed to providing the high quality benefits you have earned and deserve.

Allegations of VA employees’ misconduct have surfaced over the last several weeks, beginning with scheduling delays at the Phoenix VA Health Care System. As I testified before Congress on May 15, I take any allegations about patient

safety or employee misconduct very seriously. The reports of Veterans' negative experiences while seeking VA care are of great personal concern to me. I fully agree with President Obama's statement on May 21, 2014: "If these allegations prove to be true, it is dishonorable, it is disgraceful . . . ."

In response to these allegations at the Phoenix VA Medical Center and a number of other facilities, the VA Office of Inspector General is conducting a comprehensive, independent review. In addition to the IG's independent review, I ordered the Veterans Health Administration (VHA) to conduct a nationwide audit of all other major VA healthcare facilities to ensure understanding of, and compliance with, our appointment policy. That audit is being conducted now by more than two hundred senior VHA staff. All teams are independent of the facilities they are visiting. You and your families deserve to have full faith in your VA, and we intend to earn it every day.

As President Obama made clear to the American people May 21, 2014, "Every single day, there are people working in the VA who do outstanding work and put everything they've got into making sure that our Veterans get the care, benefits, and services that they need." I echo that praise and commend the hard work and dedication of the vast majority of our VA employees, many of whom are Veterans themselves. Every year, dedicated employees are prepared to provide care for over 8.9 million Veterans enrolled in VA healthcare. Every day, VHA conducts approximately 236,000 outpatient healthcare appointments—about 85 million last year.

Since 2009, we have enrolled two million more Veterans in high-quality VA healthcare, reduced Veterans' homelessness by 24 percent, and provided Post-9/11 GI Bill educational benefits to more than one million student Veterans and eligible family members. We have opened up new presumptives for Veterans to receive long overdue care for exposure to Agent Orange, for combat-related PTSD, and for Gulf War illnesses. And, we have decreased the disability claims backlog by over 50 percent in the last 14 months. We will meet our goal of eliminating the claims backlog in 2015.

Every VA medical facility is accredited by The Joint Commission, an independent, non-profit organization that ensures the quality of U.S. healthcare through intensive evaluation of more than 20,000 healthcare organizations. In 2012, The

Joint Commission, recognized 19 VA hospitals as top performers, and that number increased to 32 in 2013.

Since 2004, the American Customer Satisfaction Index (ACSI) survey has consistently shown that, on average, Veterans who use VA healthcare award our hospitals and clinics a higher customer satisfaction score than patients give private sector hospitals. When asked if they would use a VA medical center the next time they need inpatient or outpatient care, 96 percent and 95 percent of Veterans, respectively, indicated they would. Veterans across the Nation are receiving quality care from VA. We must encourage other Veterans to seek it. Notwithstanding these accomplishments, VA will do even better. If any allegations under review are substantiated, we will act.

As we approach our observance of Memorial Day and its special significance to our Nation, VA is re-doubling its efforts, with integrity and compassion, to earn your trust.

As President Obama said, Veterans have "done their duty, and they ask nothing more than that this country does ours—that we uphold our sacred trust to all who have served."

And, we will.
Eric Shinseki

Rep. Nolan Announces Veterans Roundtables to Discuss Critical Issues at the VA

Roundtables will be in Duluth, Little Falls, Brainerd, Center City, and Hibbing.
WASHINGTON, D.C.—U.S. Congressman Rick Nolan (MN-08) today announced the locations of several veterans roundtables to be held across the 8th District.
"With so many urgent issues concerning the VA and veterans across our nation, I urge veterans to join me at these roundtables, to share your views and experiences with me," said Nolan.

"I hope to return to Washington prepared to address the concerns of the 60,000 veterans in Minnesota's 8th District – whether it be wait times at the VA, unsubstantial benefits, or issues with access to care in rural areas."

Among the items for discussion will include H.R.635, the HEALTHY Vets Act, which would enable veterans in rural areas to visit their local doctors, rather than travel to the nearest big city for VA facilities. Rep. Nolan is a cosponsor of this bill. Congressman Nolan is additionally working on bills to increase funding and VA personnel to eliminate the backlog, fully fund the National Guard, boost veterans benefits and housing, expand services for mental health issues, and establish a Veterans Economic Opportunity Administration to help vets return to the workforce.

Duluth – Thursday, June 5
With:
Jeff Hall, Team Leader, U.S. Department of Veterans Affairs
Steve Sarri, Regional Director, Minnesota Assistance Council for Veterans
3:00 – 4:30 pm
Duluth Vet Center
405 E Superior St. Suite 160

Little Falls – Friday, June 13
10:00 – 11:30 am
Morrison County Government Center – Meeting Room 1
213 SE 1st Avenue

Brainerd – Friday June 13
With:
Bob Nelson, Director of the Crow Wing County Minnesota Veterans Service Office
2:00 – 3:30 pm
Crow Wing County Land Services Building, Meeting Room 1
322 Laurel Street

Center City – Monday June 16
3:00 – 4:30 pm
Chisago County Government Center – Lower Level
313 North Main Street

Hibbing – Wednesday, July 2
1:00 – 2:30 pm
Servicemen's Quarters
Hibbing Memorial Building
400 East 23rd Street

VA Health Care: VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times, Including Specialty Care Consults

What GAO Found

As GAO previously reported in its testimony on April 9, 2014, its preliminary work examining the Department of Veterans Affairs' (VA), Veterans Health Administration's (VHA) management of outpatient specialty care consults identified examples of delays in veterans receiving outpatient specialty care, as well as limitations in the implementation of new consult business rules designed to standardize aspects of the clinical consult process. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VA medical center (VAMC), between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. GAO's preliminary work also identified variation in how the five VAMCs reviewed have implemented key aspects of VHA's business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. Such variation may limit the usefulness of VHA's data in monitoring and overseeing consults systemwide. Furthermore, oversight of the implementation of the business rules has been limited and has not included independent verification of VAMC actions. Because of the preliminary nature of this work, GAO is not making recommendations on VHA's consult process at this time.

In its December 2012 report, GAO found that VHA's outpatient medical appointment wait times were unreliable. The reliability of reported wait time performance measures was dependent in part on the consistency with which schedulers recorded desired date—defined as the date on which the patient or health care provider wants the patient to be seen—in the scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. GAO also found that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely medical appointments. For example, GAO identified clinics that did not use the electronic wait list to track new patients in need of medical appointments as required by VHA policy, putting these patients at risk for not receiving timely care. VA concurred with the four recommendations included in the report and, in April 2014, reported continued actions to address them. For example, in response to GAO's recommendation for VA to take actions to improve the reliability of its medical appointment wait time measures, officials stated the department has implemented new patient wait time measures that no longer rely on desired date recorded by a scheduler. VHA officials stated that the department also is continuing to address GAO's three additional recommendations. Although VA has initiated actions to address GAO's recommendations, continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, these delays have resulted in harm to patients.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the appointment scheduling process. Also in 2012, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. In May 2013,

VHA launched the Consult Management Business Rules Initiative with the aim of standardizing aspects of the consults process.

This statement highlights (1) preliminary observations GAO made in an April 9, 2014, testimony statement regarding VHA's management of outpatient specialty care consults, and (2) concerns GAO raised in its December 2012 report regarding VHA's outpatient medical appointment scheduling, and progress made implementing GAO's recommendations. To conduct this work, GAO reviewed documents and interviewed officials from VHA's central office. Additionally, GAO interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location.

Walz & Veterans Groups Meet with Local VA Officials to Talk Wait Times for Medical Care

Mankato, MN [5/14/14] – Today, Representative Tim Walz (MN-01) and a group of leaders from local veterans' service organizations visited U.S. Department of Veterans Affairs (VA) medical facilities in Mankato, Minneapolis and Rochester to request information from local officials about wait times for medical care. Walz is a member of the House Veterans Affairs Subcommittee on Oversight and Investigations that is looking into the troubling allegations of a secret wait list for veterans at the Phoenix, Arizona hospital.

"As both a veteran and a member of this committee, I expect our warriors to receive the support and care they have earned and deserve. I will be the VA's strongest ally, but also their harshest critic when warranted. The allegations coming out of the Phoenix VA are extremely troubling and have rattled peoples' faith in the system. I am concerned that unless we get all of the facts on the table more damage will be done to the confidence of veterans seeking care. I appreciate the cooperation I'm receiving from local VA officials with my inquiry."

Last week, Walz joined the House Veterans Affairs Committee in voting unanimously to subpoena certain emails and written correspondence from VA officials, including VA Secretary Eric Shinseki, in an effort to provide oversight and get to the bottom of allegations of a "secret wait list" at the Phoenix, Arizona VA hospital.

There is no evidence of a “secret wait list” at Minnesota VA facilities, but Walz is asking for a full accounting of the data and the appointment scheduling process used locally. Specifically, Walz questioned local VA officials about "wait times" veterans are experiencing when seeking care locally.

“My goals are to get to the bottom of what happened in Phoenix and determine whether these allegations are widespread in the VA across the country. This includes getting a full accounting of the scheduling process used at our local VA facilities. Ultimately, any problems that are discovered must be fixed, people must be held accountable, and the VA must restore veterans’ full faith in the system. Veterans who need medical care can't be discouraged from seeking treatment or turned away when they need services."

UPDATE:
The VA recently provided Walz with the following information regarding appointment wait times (See links below). It should be noted that this is not a full accounting of the data nor does it fully answer Representative Walz’s questions he laid out in his May 9 letter to VISN Director Murphy. While Representative Walz was told during the meeting that there was no evidence of a secret wait list in Minnesota, he is still demanding from the VA a full accounting of the data and scheduling processes used in order to verify what he was told and to get full answers to the questions laid out in his May 9 letter.

Please see the links below for the May 9 letter to Director Murphy and for more information from the VA.
Rep. Walz’s Letter to VISN Director Murphy
PDF of VA’s Presentation to Rep. Walz on Wait Times
Fact Sheet from the VA on Wait Times in Minneapolis, Mankato, and Rochester

D-Day Update ► Dutch Minister Pays Tribute at Arlington

In honor of the upcoming 70th anniversary of Operation Overlord in Normandy, the Dutch foreign affairs minister visited Arlington National Cemetery 30APR to pay tribute to American World War II soldiers laid to rest in the Netherlands.

Frans Timmermans met with American World War II veterans and spoke at the Women in Military Service to America Memorial, placed flowers at the graves of four Dutch military personnel who are buried at Arlington and visited the Tomb of the Unknown Soldier. "I'm here to thank and to pay tribute to all these servicemen who made sure I'm free, my children are free and that we could live our lives the way we want to," Timmermans said before he began his speech.

In his remarks, Timmermans said the people of the Netherlands continue to honor the American fallen of World War II by personally adopting each of the more than 8,000 graves of American servicemen who are buried in the Netherlands American Cemetery and Memorial in Margraten, located in Limburg, the most southerly Dutch province. Margraten is one of the 24 American burial grounds on foreign soil that are administered, operated and maintained by the American Battle Monuments Commission. More than 8,000 American servicemen are buried there -- 8,000 of the 93,000 American soldiers who found their final resting place in Europe during World War II. "They sacrificed their lives so that people in Europe could live in freedom," the minister said. "Anyone who wants to feel the strength of the transatlantic partnership – to feel what lies at its heart – should visit Margraten or other military cemeteries that dot the landscape of Western Europe. All the graves at Margraten have been adopted by private citizens, most of them Dutch, as an expression of our everlasting gratitude and our determination to kekeep these memories alive."

Retired Army Technician 3 Marvin Lykins, a World War II veteran on hand for the event, said he was honored to meet the Dutch minister. "It was a little overwhelming, but great to see that World War II veterans aren't forgotten," said the former medical technician who served in France and Germany. "I've had so many people come up and say, 'Thank you' -- both children and adults. It's very emotional." As part of his mission to have these soldiers remembered for their service in liberating the Netherlands, Timmermans has personally adopted the grave of Army Pfc. Leo Lichten, who was killed in action almost 70 years ago, and has taken time to learn about him. Lichten was one of the 169 American soldiers who died during Operation Clipper, a joint U.S.-British assault on the Geilenkirchen salient of the Siegfried Line. "When I got his grave, I didn't know anything about him. ... I started looking on the Internet, into records, finding other servicemen who could help me," the minister said. "I found his childhood friend. I learned more about the sacrifice the American servicemen made for our

liberty. And I learned more about our common history. We can use these concrete examples, these young guys who came over to Europe and fought for our liberty as a testimony to the lasting bond between the Netherlands and the United States."

For Leo Slater, the minister's visit was a reunion and a special honor. Slater was named after Lichten. His father, Paul Slater, a retired Navy World War II veteran, grew up with Lichten in Brooklyn, N.Y. Paul Slater met with the minister and showed him letters Lichten had written him during Lichten's time at training and in Europe. He also gave the minister a better appreciation of who Lichten was, Timmermans said. Leo Slater said he grew up on the stories about Lichten, and was honored to carry on the name and to attend the minister's event. "I was really touched and really enjoyed the speech. It really is a bond of blood and culture," he said. "It's important to have events like this, because we are losing more World War II veterans every day, and we need to make that transition from just memory into history and have people understand why it is and where we are today. "We're coming up to the 100th anniversary of World War I, and the living memory of that is virtually gone," he continued. "It's important to remember why these people died." Four years ago, Timmermans arranged for Leo Slater and his father to visit Lichten's grave in the Netherlands together for the first time. Leo said it gave his father closure. It was the three of us standing in the rain at a grave. My father stood there and said, 'I told you I would find you,' and he did," Slater said, getting choked up. "My dad and his friends all signed up; Leo was the one who was supposed to have stayed, but was the one in the group who didn't come back. My dad didn't get over it for a long time, if he ever did. There was no question about him naming his son after Leo."

While Lichten has been identified, 1,722 names of American service members are still listed on the Walls of the Missing in the Netherlands. "The story of our liberators will never cease to fill me with awe," Timmermans said. "And the personal stories of these men deserve to be retold. I am proud that I could unearth more details about the story of Leo Lichten."The stories of many others remain untold," he said. "I very much support the efforts of the foundation behind the initiative to adopt individual graves, to collect more information about the soldiers buried and honored at Margraten. I very much support their desire to collect photos of these men, to give these heroes a face. Incredibly, there are still soldiers buried there of whom there is no photo, no recollection whatsoever. It is

something we owe to those who died. It is something we owe to those who live."
[Source: Defense Media Activity | Shannon Collins | 1May 2014 ++]

Arlington National Cemetery Update ► Origin

On 13 MAY as Arlington National Cemetery marks the 150th anniversary of its first burial, it is a scene of harmony and reconciliation. It didn't start that way. Before the Civil War, the property overlooking the Potomac River -- called the Custis-Lee Mansion or Arlington House -- was the home of Robert E. Lee. The house and grounds belonged to Lee's wife, Mary, and in 1861 the Lee family had called Arlington home for 30 years. Lee was at Arlington House when he received word that Virginia had seceded from the Union in April 1861. This caused a crisis for Lee, who was a U.S. Army colonel at the time. He had been offered command of the Union Army, and he agonized over the decision on whether to stay with the Union or go with his state. On 20 APR, Lee submitted his resignation from the Army. He left Arlington House two days later. He ultimately rose to command the Confederate army.

Across the river in Washington, another Southern officer came to a different decision. Montgomery C. Meigs was a Georgian who graduated from West Point and as a Corps of Engineers officer and had built many of the major projects of the day. Meigs considered his oath to "support and defend the Constitution" as paramount, and when his home state of Georgia seceded, he stayed with the Union. Meigs rose to be quartermaster general of Union forces. He was one of the first officers anywhere to understand the importance of logistics in military operations, and he welded together a system that capitalized on the Union's manufacturing and transportation expertise. For Arlington House, whether Lee stayed with the Union or went with Virginia didn't really matter in 1861, because the property was so strategically important, Arlington National Cemetery historian Stephen Carney said. The property included high ground and dominated two bridges into the district. If Confederate forces placed artillery units on the heights, they would have had everything from the White House to the Capitol and more in range. In one of the first movements of the Civil War, Union forces occupied Arlington and built two forts on the heights as part of the defenses for Washington.

Lee's family lost the land for failure to pay tax on the land. Mary Lee had attempted to pay the tax -- a total of $92.07. She did not appear in person, but asked an agent -- possibly her cousin, to do so, according to Carney. But the federal government refused to accept the tax payment from that person. The government acquired the house and land for $26,800 in 1864 and built a Freedman's Village on the property to house the freed slaves who gravitated to Washington. On April 30, 1864, the Army of the Potomac began the Overland Campaign against the Army of Northern Virginia. Union Lt. Gen. Ulysses S. Grant moved across the Rappahannock River and immediately ran into Lee's forces at the Battle of the Wilderness. But instead of a one-day battle, as was the case before, the warfare ground on with battles in Spotsylvania, Yellow Tavern, North Anna, Cold Harbor and so on. It was a blood-letting the likes of which the world hadn't seen. Estimates vary, but Civil War historians put the number of casualties in the range of 55,000 for the Union and 34,000 for the Confederates.

Washington was the closest city and served as the base of operations. It was a hub where rivers, roads and rail came together. It was both a supply center and a hospice, Carney said. And in charge of it all was Union Brig. Gen. Montgomery Meigs, the quartermaster general. Meigs detested the Confederacy and the officers who had betrayed their oaths to the United States of America. He was responsible for supplying the needs of the Union Army, and he also was responsible for burying them. In May 1864, the graveyards of Washington and neighboring Alexandria were overwhelmed by the demand. Meigs ordered a review, Carney said. Engineers came back saying that Arlington was the most suitable site. "It was high above the river and the center of many roads," Carney said. That it was the home of Robert E. Lee -- the author of much of the destruction -- was not lost on Meigs, Carney said. Meigs had served under Lee in the pre-war Army as the two worked to improve navigation on the Mississippi River. They knew each other well. When Lee followed his state, Meigs felt betrayed. Establishing a cemetery on the property would ensure the Lee family could not re-occupy the land or house, Carney said.

The first military burial at Arlington was Pvt. William Henry Christman on May 13, 1864. The 67th Pennsylvania Infantry soldier was buried a good distance north of Arlington House. Meigs saw this and ordered the next burials to be in what was Mary Lee's rose garden, feet from the door to Arlington House, Carney said. Meigs formally declared the cemetery open in June 1864, and thousands of

burials followed. At the end of the war, Meigs gathered the bones of thousands of Union soldiers that had been hastily buried at Virginia battlefields, and placed them in a burial vault in the rose garden. The Lee family ultimately received payment from the federal government for Arlington House, but no one ever lived in the house again, Carney said.

The cemetery became a focal point during Decoration Day. Thousands of Americans journeyed to Arlington to place tributes on the graves of those buried at Arlington. The cemetery also became a visible sign of reconciliation -- it features a Confederate Monument with the graves of Confederate veterans around it. The construction of the Memorial Bridge in 1932 symbolically linked the Lincoln Memorial in Washington with Arlington House in the midst of the cemetery. [Source: AFPS | Jim Garamone | May 13, 2014 ++]

MERS-CoV ► GEIS Detects Earliest-Known Cases

A Defense Department-funded lab in Egypt detected the earliest-known cases of Middle East Respiratory Syndrome virus, a new coronavirus strain that is infecting people on the Arabian Peninsula, an expert from DOD's global disease surveillance system said. It was identified in 2012 as the cause of respiratory illness in people. Investigations are ongoing to discover the source of MERS-CoV and how it spreads.

The lab shared samples so the Centers for Disease Control and Prevention could develop tests for the virus, said Public Health Service Capt. Michael J. Cooper, head of respiratory disease for the Global Emerging Infections Surveillance and Response System, called GEIS, which is part of the Armed Forces Health Surveillance Center. GEIS is a funding agency that supports military laboratories in the United States and in Egypt, Germany, Kenya, Peru, Thailand and Singapore -- all of which serve as hubs for infectious disease surveillance and as regional hubs for addressing global public health issues -- and it funds respiratory disease surveillance projects at 400 sites in more than 30 countries. As of 9 MAY, the World Health Organization, or WHO, reports 536 laboratory-confirmed cases of MERS-CoV since April 2012, including 145 deaths. Some people infected with MERS-CoV develop severe acute respiratory illness with symptoms of fever, cough and shortness of breath, and about 30 percent of known cases die, according to

the CDC. Some people exposed to the virus get only a mild respiratory illness, the CDC reported.

A CDC fact sheet says MERS-CoV has spread between people in close contact and from infected patients to health careworkers. Clusters of cases in several countries are being investigated, as is the source of the new strain. MERS-CoV has been found in camels in Qatar, Egypt and Saudi Arabia, and in a bat in Saudi Arabia. Camels in other countries have tested positive for MERS-CoV antibodies, meaning they have been infected with MERS-CoV or a closely related virus. But CDC says it needs more information to identify the potential roles of camels, bats or other animals in MERS-CoV transmission. On 2 MAY, CDC reported the first confirmed U.S. case in a health care worker traveling from Saudi Arabia to London to the United States. The patient was hospitalized in Indiana and at the time was in stable condition. During a recent interview with AFPS, Cooper said, "[GEIS's] first objective is force health protection" for U.S. troops, "but we are also involved with global public health issues. We also do surveillance on diseases that aren't necessarily militarily relevant but are relevant to global public health because sick people can board aircraft and carry infectious diseases anywhere in the world within 24 hours."

One of GEIS's funded laboratories is the Naval Medical Research Unit-3, or NAMRU-3, the largest DOD overseas lab, formally established in Cairo in 1946. Scientists there conduct research on a range of diseases and perform infectious disease surveillance to support military personnel deployed to Africa, the Middle East and Southwest Asia. NAMRU-3 also works closely with the Egyptian Ministry of Health and Population, the U.S. National Institutes of Health, WHO and CDC, and is a WHO regional Collaborating Center for HIV and Emerging Infectious Diseases. Cooper said GEIS funds the Jordan National Influenza Center, called the NIC, and that NAMRU-3 and members of the Jordan Ministry of Health and the NIC work together often. The news has "caused a lot of concern," Cooper said, "because the last time the world saw an emerging coronavirus strain was 2002-2003, and it was severe acute respiratory syndrome -- SARS -- which caused about 8,000 cases and 780 deaths" in more than 24 countries.

Cooper defines infectious disease surveillance as "basically collecting data in a systematic way so that disease levels can be monitored. Hopefully this information gives you an idea of the distribution of a given disease and hopefully

helps to understand what populations are affected." Doing surveillance, he said, usually involves "testing people who are ill and in some cases testing people who are not ill but who may have been exposed to the virus." All DOD major infectious disease labs have surveillance capabilities for MERS-CoV, Cooper added, and all DOD major medical centers around the world have MERS-CoV diagnostic capabilities. GEIS does surveillance for a range of diseases, he said, including H7N9 influenza emerging in China, enteric infections like those caused by contaminated food or water, parasitic infections like malaria, other respiratory infections like multidrug-resistant tuberculosis, and sexually transmitted infections.

Cooper said respiratory diseases are the ones that typically go pandemic because of the way they spread. "The most recent examples are SARS and the pandemic of 2009, which was H1N1 influenza," he said. "They spread easily from person to person and they don't kill their hosts too soon or maybe at all." About MERS-CoV, Cooper said, "We were well ahead of the curve on this one and we have a very strong network of respiratory disease surveillance." He added, "We'll also say this, though. We're dealing with a virus and viruses can change and quite frankly frequently do change. So you have to monitor the situation and you have to be careful. Surveillance is key in this situation. You have to know what's going on." [Source: AFPS | Cheryl Pellerin | May 12, 2014 ++]

Medical Marijuana ► Health Insurers Won't Be Paying For It

Just say no. That's health insurance companies' response to paying for medical marijuana. The Associated Press said medical marijuana treatments can cost upward of $1,000 a month, an unwanted hit that patients have to cover themselves. Marijuana has gained acceptance for its ability to dull pain and other chronic symptoms of conditions ranging from epilepsy to cancer. Despite medical marijuana being legal in 21 states, health insurers won't be paying for the treatment anytime soon, in part because of conflicting laws. Pot is still illegal under federal law and in 29 states. And, according to AP: Perhaps the biggest hurdle for insurers is the U.S. Food and Drug Administration hasn't approved it. Major insurers generally don't cover treatments that are not approved by the FDA, and that approval depends on big clinical studies that measure safety, effectiveness and side effects. Clinical research costs millions of dollars and can

take years to complete. The FDA has approved treatments that contain a synthetic version of an ingredient in marijuana. But at this point there's been no approval for a treatment that uses a real marijuana plant. Clinical studies for marijuana are also a challenge because pot is classified as a Schedule I drug. That classification of drug, which includes heroin, is deemed to have a significant potential for abuse and no accepted medical use, according to LifeHealthPro, a life and health insurance adviser site. "Because health care plans and insurance policies typically exclude coverage for experimental treatments, insurers may continue to decline payment for marijuana as long as it remains on Schedule I," LifeHealthPro said.

Says the AP: The American Medical Association has called for a change in marijuana's classification to one that makes it easier for research to be conducted. The current classification prevents physicians from even prescribing it in states where medical use is permitted. Instead, they can only recommend it to patients. The AP added: Even if the FDA approves medicinal marijuana, there's no guarantee that insurance coverage will become widespread. Big companies that pay medical bills for their workers and dependents decide what items their insurance plans cover. They may not be eager to add the expense. [Source: MoneyTalksNews | Krystal Steinmetz | May 12, 2014 ++]

VA Medical Records Update ► 1.5M Backlogged Consults Cancelled

More than 1.5 million medical orders were canceled by the Department of Veterans Affairs without any guarantee the patients received the treatment or tests they needed, the Washington Examiner has found. Since May 2013, veterans' medical centers nationwide have been under pressure to clear out 2 million backlogged orders for patient care or services. They were given wide latitude to cancel unfilled appointments more than 90 days old. By April 2014, the backlog of what the agency calls "unresolved consults" was down to about 450,000. What happened to other 1.5 million appointments is something that no one, including top officials at the veterans' agency, can answer.

A review by the Government Accountability Office of the process VA used to close old consult orders found that poor documentation in patient files and the lack of independent verification made it impossible to know whether patients got care

they needed before their medical orders were canceled. “We found they closed consults but there was no evidence as to why it was closed,” Debra Draper, health care director for the GAO, told the Examiner. “By not having that independent verification or any other controls, there isn’t any way of knowing whether they were appropriately closed out,” Draper said. “You don’t know whether people received the care or if they received it in a timely manner. There’s no audit trail. There’s no way to know whether they were appropriately closed,” she said. The Examiner reported in February that the VA did a mass purge of backlogged medical orders that cleared 40,000 unresolved appointments in Los Angeles beginning in 2009 and 13,000 in Dallas during a one-week period in September 2012.

VA officials have since refused to say how widespread is the practice of canceling orders by labeling them “administratively closed” or how many unfilled consult orders were eliminated nationwide. VA officials have also given conflicting statements about the issue to the media, Congress and the agency's own inspector general. VA is under pressure to eliminate the long waits patients face when they need potentially life-saving medical tests. A Veterans Affairs fact sheet released in April said 23 patients at VA medical facilities nationwide with gastrointestinal cancers died after they could not get the colonoscopies or other tests that had been ordered within the deadlines in agency policy. Those tests could have detected the cancers in their early stages, when they are most treatable. The total number of deaths linked to delayed care from other medical disorders was not revealed. At least 40 patients in the Phoenix VA health system may have died as a result of delayed care, according to an investigation by the House Committee on Veterans Affairs and reports by the Examiner and other news media outlets.

At a hearing in April, committee chairman Jeff Miller (R-FL) ordered records at the Phoenix facility to be preserved, while the agency’s inspector general probes allegations that two sets of appointment logs were kept to hide long wait times for medical care. Allegations that almost 60,000 overdue medical orders were purged in Phoenix to cover long wait times also have been raised by whistleblowers. It’s not clear how long the VA has been mass-closing backlogged orders for tests and other procedures. The Los Angeles purge began in 2009, when hospital administrators were under orders from Washington to reduce the backlog of unfilled consults, according to Oliver Mitchell, a whistleblower who

formerly worked as a scheduling clerk in the Los Angeles facility's radiology department. Mitchell filed separate complaints to the inspector general and the U.S. Office of Special Counsel in 2009 alleging thousands of tests were canceled. Both complaints were closed after investigators did a cursory review and received assurances from VA officials that all patients who needed care got the ordered procedures. In Dallas, the 13,000 cases were administratively closed in about a week in September 2012.

A consult is an order for follow-up care from a medical provider ranging from a diagnostic test such as a colonoscopy to an order for transportation to a medical facility. In 2012, officials at the VA headquarters in Washington tried to build a database to track consult orders. But the database proved to be useless because of poor record keeping and the lack of standard procedures for tracking and filling the orders, Draper told the House veterans committee in April. In May 2013, a directive was sent to medical centers across the country to clean up the records and clear out outdated and unfilled orders that were no longer needed. Before an order was closed, the case was supposed to be reviewed to ensure the treatment was no longer required. But an ongoing review by GAO found lax procedures and the lack of independent verification left VA unable to prove that all patients got the care they needed before the appointment was closed. At one facility reviewed by GAO, patients in three of the 10 cases examined did not get the ordered procedures before their consults were closed. At another, 18 consult orders were canceled on the day the facility was required to have the cases resolved. GAO reviewed three of those cases and “found no indication that a clinical review was conducted prior to the consults being discontinued.”

Some of the 1.5 million backlogged consults were probably closed appropriately, Draper told the Examiner. In some cases, the patient received the test but the verification was not correctly entered into the patient’s file. In those cases, closing the consult order would be appropriate. Some of the closed consults were administrative tasks, such as transportation orders, and in others the medical procedure was no longer required because the patient’s treatment plan had changed or the patient died. But there is no way to tell how many of the orders were appropriately filled or canceled, Draper said. A large proportion were simply “administratively closed” without any sign the appropriate review was done or the patient ever received the needed care that had been ordered, she said. VA officials refused to be interviewed for this story. They have issued a variety of

statements in the past both acknowledging and denying mass cancellations of backlogged consult orders.

In response to Mitchell's whistleblower complaint, VA officials in Los Angeles told the inspector general they were orderedby Dr. Charles Anderson, then national radiology director at VA, to “mass purge all outstanding imaging orders” that were more than six months old. An internal VA memo from Dallas in September 2012 said medical staff would “aggressively address this backlog of unresolved consults and reduce the number to an acceptable level.” However, after the Examiner reported on the Los Angeles and Dallas purges, Robert Petzel, under secretary for health at VA, said only a few hundred cases in the Los Angeles facility had been administratively closed. Petzel also said he had never heard the 40,000 figure cited by the Examiner, which was initially raised during a congressional hearing a year earlier. The same day, Dr. Dean Norman, chief of staff for the VA Greater Los Angeles Healthcare System, said in an agency blog post that several hundred old orders had been closed in Los Angeles after careful administrative review. “At no time were ‘group’ close-outs of imaging studies completed,” Norman said.
The one consistency in VA’s explanations has been that cases were closed only after careful, individual reviews, and that no patient who needed care was denied care. Draper said that is not a claim VA can back up. Reviewing cases individually, as GAO did, is tedious and time-consuming, Draper said. It is unlikely such a careful analysis could have been done on 13,000 cases in Dallas in about a week, much less 1.5 million cases nationally in a year, she said. GAO is still investigating the large-scale closing of unfilled consult orders and its findings should be published this summer. The VA inspector general is also conducting an investigation into allegations first raised by the Examiner of the Los Angeles and Dallas mass purges. After the Examiner's story was published, Republican Reps. Kevin McCarthy of California and Dan Benishek of Michigan asked for in an internal agency investigation. Benishek is chairman of the House Veterans' subcommittee on health and a former VA surgeon. A similar request was sent by Rep. Pete Olson, R-Texas.

Petzel responded in an April 9 letter to Benishek that the inspector general would handle the investigation. Petzel did not respond to questions on the accuracy of the Examiner's reports or if the mass-purge practice was being used at other VA medical facilities. “It’s unacceptable,” Benishek said of the response he’s gotten

from the VA. “It’s a 'CYA' philosophy.” Prior investigations by the GAO and inspector general found hospital administrators had an incentive to show steep declines in appointment backlogs. Performance reviews and bonuses are tied in part to meeting agency goals for reducing patient wait times. GAO also identified several ways local facilities manipulated appointment lists to show it was meeting agency rules for wait times. Sharon Helman, the director of the Phoenix VA health system, got a $9,345 bonus last year. Draper said the bonus incentives and weak oversight make it easy for VA hospitals to manipulate their statistics. “There are incentives that may encourage bad or unwanted behaviors,” she said. “There are weak system designs that really allow for manipulation if that’s what’s desired.”
[Source: Washington Examiner | Mark Flatten | MAY 1, 2014 ++]

John Kline Supports National Defense Legislation, Keeps Promises to Veterans

WASHINGTON – Minnesota Congressman John Kline supported the bipartisan National Defense Authorization Act (NDAA) which passed the U.S. House of Representatives today. H.R. 4435 serves as the budgetary blueprint for the pentagon – balancing our national security needs and responsible government spending.

“At a time when the government’s commitment to those that have served our nation has come into question, I am pleased to have supported this legislation which is critical to our service men and women, our veterans, and their families,” said Kline, a 25-year veteran of the U.S. Marine Corps whose wife is a retired Army nurse and son has served three tours in Iraq and Afghanistan. “As the nation reflects on those that laid down their lives for our freedoms this Memorial Day, I am proud to support legislation that keeps promises made to our veterans and provides needed support for our troops.”

Included in this year’s national defense bill is a provision which, in the wake of reported misconduct by senior DoD officials, directs the Government Accountability Office (GAO) to review current military ethics programs and provide Congress with an evaluation so needed oversight can be conducted.

Kline’s legislation directing the Pentagon to issue a report detailing how it

increased health care costs for more than 4,000 Minnesotans who were covered under the TRICARE Prime program but later removed by the Department of Defense was also incorporated into the national defense bill.

In addition to Kline's proposals, the legislation maintains the annual pay increase for our troops and rejects the Administration's cuts to TRICARE, Commissary benefits, and Housing allowances.

Congressman John Kline serves on the House Armed Services Committee. He also serves as the Chairman of the Education and the Workforce Committee. He and his wife, Vicky, live in Burnsville.